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New York State EPIC Prescription Protection for Seniors

APPLICATION

PLEASE PRINT CLEARLY

FILL OUT THIS FORM COMPLETELY.

ENTER THE ADDRESS THAT WE SHOULD USE WHEN WE SEND YOU INFORMATION.

REMEMBER:

- YOU MUST BE 65 OR OLDER TO ENROLL.
- **YOU MUST SEND PROOF OF AGE WITH YOUR APPLICATION.**

Who is applying? ☐ Yourself only or ☐ Yourself and your spouse

Your Last Name First Middle Initial

c/o Name (if different from above)

Mailing Address Box # or Apt. #

City County Zip

Social Security Number

Your Date of Birth
Month Day Year

Telephone Number
Area Code Number
( )

Marital Status
☐ Widowed, Single or Divorced
☐ Married
☐ Married, Living Separately

Sex
☐ Female
☐ Male

Ethnic Information (Optional)
☐ White ☐ Black ☐ Hispanic
☐ Asian ☐ Native American
☐ Other

Spouse's Last Name (If Living) First Initial Social Security Number

Spouse's Birthdate
Month Day Year

Spouse's Ethnic Information (Optional)
☐ White ☐ Black ☐ Hispanic ☐ Asian
☐ Native American ☐ Other

Do you have other insurance that covers prescriptions? ☐ Yes ☐ No
If yes, name of other insurance _____

Does your spouse have other insurance that covers prescriptions? ☐ Yes ☐ No
If yes, name of other insurance _____

Do you have Medicaid? ***(Not Medicare)*** ☐ Yes ☐ No
If yes, do you have a Medicaid spenddown? ☐ Yes ☐ No
Does your spouse have Medicaid? ***(Not Medicare)*** ☐ Yes ☐ No
If yes, does your spouse have a Medicaid spenddown? ☐ Yes ☐ No

(Please turn over and fill in other side)

NEED HELP? CALL TOLL-FREE: 1-800-332-3742
¿ NECESITA AYUDA? LLAME 1-800-332-3742

Report your total income for the previous calendar year.

- If you are married, you must report the joint income of you and your spouse.
- Fill in each line. Where you did not have income, check the NONE box.
- Report all income including Social Security (without Medicare Premiums), pensions, interest from savings, IRA distributions, wages, etc. Multiply monthly amounts by 12 to get yearly income.
- Your income information may be verified with the Social Security Administration, the NYS Department of Taxation and Finance and others. We may ask for copies of documents that verify your income.

	YOUR YEARLY INCOME	NONE	SPOUSE'S YEARLY INCOME	NONE
1. Social Security (without Medicare) and/or Railroad Retirement Benefits	$ _____	☐	$ _____	☐
2. Pensions and Annuities	$ _____	☐	$ _____	☐
3. Other Income (Net Rental Income, IRA, Capital Gains, Wages, Business Income or Loss, etc.)	$ _____	☐	$ _____	☐
4. Interest and Dividends	$ _____	☐	$ _____	☐
5. TOTAL YEARLY INCOME (Add lines 1-4)	$ _____		$ _____	

Read carefully and sign below:

I certify that the information on this form is correct. I reside in New York State, and am not currently receiving Medicaid benefits. I know that I may be required to give proof of my age, income, residency and other prescription insurance. I know that I do not have to disclose my Social Security number; but if provided, it will be used to verify my eligibility under Article 19-K of the Executive Law. I consent to the exchange of all information necessary to verify my eligibility between EPIC and the Social Security Administration, NYS Medicaid Program, NYS Tax Department, private insurance companies and others. In the event of duplicate or overpayment by EPIC, I assign to EPIC any drug benefits that I may be entitled to under any other private insurance or governmental plan. I authorize my health care providers to release to the EPIC program my medical information pertaining to prescriptions to be used for authorized program purposes.

You or your representative must sign below:

_____ Your signature

_____ Date

_____ Spouse's signature

_____ Date

Mail this form with proof of age, and income documentation if available, to:

EPIC
P.O. Box 15018, Albany, NY 12212-5018

The information on this application is kept strictly confidential and is used only to determine your eligibility for EPIC.